APPLICATION FOR REGISTRATION FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY CLINICAL FELLOWSHIP YEAR

State Form 50320 (7-01)
Approved by State Board of Accounts, 2001

HEALTH PROFESSIONS BUREAU
402 West Washington Street, Room 041
Indianapolis, Indiana 46204

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

FEE	
DATE FEE PAID	
RECEIPT NUMBER	
REGISTRATION NUMBER	
DATE ISSUED	

DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number*	
Address (*number and street or rural route*)			
City		State	ZIP code
Date of birth	Place of birth (*city and state or country*)		
Telephone number (*daytime*)		E-mail address	

SCHOOL OF GRADUATION

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION (*Mo., Day, Yr.*)

MASTER'S DEGREE GRANTED IN:

☐ Speech-Language Pathology ☐ Audiology

* If your clinical fellowship begins prior to the date of graduation, you must submit a letter from the school which indicates that all requirements have been completed and the date the applicant will graduate.

CLINICAL FELLOWSHIP ANTICIPATED STARTING AND COMPLETION DATE

STARTING DATE	COMPLETION DATE

LOCATION OF FELLOWSHIP

Name of hospital or facility		
Address (*number, street, or Rural Route*)		
City	State	ZIP code
Telephone number	E-mail address	

LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER

(*Continued on reverse side.*)

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a registration issued pursuant to this application.	
1. Have you ever previously filed an application in the State of Indiana?	☐ Yes ☐ No
2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	☐ Yes ☐ No
3. Have you ever been denied a license, certificate, registration or permit to practice speech-language pathology or audiology or any regulated health occupation in any state *(including Indiana)* or country?	☐ Yes ☐ No
4. Are you now being, or have you ever been treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to: A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)*	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. I am aware of the requirements set forth in 880 IAC 1-1-3.1 and understand that I may practice under the direct supervision of the person whose name appears on this application until the expiration of my registration. I hereby certify under penalties of perjury that I have completed all requirements for a master's degree as required by IC 25-35.6 -1-5(2).

Signature of applicant	Date signed (*month, day, year*)

CLINICAL FELLOW SUPERVISOR'S INFORMATION

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

SUPERVISOR'S INFORMATION		
Name (*last, first, middle, maiden*)		Social Security number *
Indiana license number		Expiration date
Address (*number, street, or Rural Route*)		
City	State	ZIP code
Telephone number	E-mail address	

CLINICAL FELLOW INFORMATION		
I will be supervising the following clinical fellow, at the dates indicated and at the following location(s):		
Name of Clinical Fellow		Social Security number *
Starting date		Completion date
Name of hospital or facility		
Address (*number, street, or Rural Route*)		
City	State	ZIP code
Telephone number	E-mail address	
LIST ANY ADDITIONAL WORK SITE ADDRESSES ON A SEPARATE SHEET OF PAPER		

APPLICATION AFFIRMATION	
I am aware of requirements set forth in 880 IAC 1-1-3.1 and understand and agree that I shall supervise the person for whom this application is submitted.	
Signature of supervisor	Date signed (*month, day, year*)

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**